BIPOLAR DISORDERS Factsheet

August 2021

How is bipolar disorder diagnosed?

Bipolar disorder is characterised by episodes of mania, or less severe hypomania, and depression. A depressive episode is a period of at least two weeks in which a person has primarily intense sadness or despair and/or feelings of helplessness, hopelessness or worthlessness. There may also be loss of interest in activities once enjoyed, feelings of guilt, restlessness or agitation, sleep problems, slowed speech or movements, changes in appetite, loss of energy, difficulty concentrating, remembering or making decisions, and/or thoughts of death or suicide.

A manic episode is a period of at least one week when a person is high spirited or irritable in an extreme way most of the day for most days. There are changes in normal behaviour such as showing exaggerated self-esteem or grandiosity, less need for sleep, talking more than usual, talking more loudly and quickly, being easily distracted, doing many activities at once, scheduling more events in a day than can be accomplished, embarking on very risky behaviour, having uncontrollable, racing thoughts, and/or quickly changing ideas or topics. These changes in behaviour are significant and clear to friends and family and are severe enough to cause major dysfunction.

What is the evidence on the diagnosis and detection of bipolar disorder?

For adults

Moderate to high quality evidence finds reasonable diagnostic stability of bipolar disorder over time. There was better inter-rater and test-retest reliability for diagnosing bipolar disorder using any method, than for diagnosing schizoaffective disorder, schizophrenia, or unipolar depression. People diagnosed with bipolar disorder may be older, married, have a later age of illness onset, shorter duration of illness, have less psychotic and negative symptoms (e.g. social withdrawal), less depression, more years of education, and more likelihood of being Caucasian than people diagnosed with schizoaffective disorder.

Moderate to high quality evidence suggests the screening tools Hypomania Checklist, Bipolar Spectrum Diagnostic Scale, and Mood Disorder Questionnaire have good accuracy for detecting bipolar disorder in mental healthcare settings. The Hypomania Checklist was better at detecting bipolar disorder II than the Mood Disorder Questionnaire. Moderate quality evidence finds reasonable predictive value and moderate agreement for bipolar disorder diagnosis between administrative databases using the ICD-10, and clinical or research diagnoses. However, an estimated 17% of people in primary care settings that were diagnosed with depression had undiagnosed bipolar disorder. Results from structural and functional neuroimaging studies analysed using machine learning techniques, show similar, moderate levels of accuracy for determining bipolar disorder diagnosis from other psychiatric diagnoses or healthy controls.

For children and adolescents

Moderate quality evidence suggests the clinical features associated more often in children or youth with bipolar depression than in children or youth with unipolar depression include; more psychiatric comorbidities and behavioural problems (i.e. oppositional disorder, conduct disorder, anxiety disorders, irritability, suicidal/self-harm, social impairment, substance use); earlier onset of mood symptoms; more severe depression; and having a family history of any psychiatric illness.

There is good reliability of checklists for identifying bipolar disorder in children. Checklists are better at detecting bipolar disorder than at detecting schizophrenia or schizoaffective disorder, but not as good as detecting unipolar depression. Caregiver report was more accurate at detecting bipolar disorder than youth self-report or teacher report, and checklists that focus on manic symptoms were most accurate.

For further information see the technical table

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